TAY OF A DISCHARGE STATE AND RELATED AND REPROCESS WIND PLAN OF CORRECTION NAME OF PROVIDER OR SUPPLIER SILAND HOME PARK HEALTH AND REHAB SUMMARY STATEMENT OF DEFICIENCES (TYS. STATE, ZIP CODE 1758 HILLWOOD DRIVE KNOXVILLE, TN 37920 EACH DEFICIENCY MAINT BE PRECEDED BY FULL REGISTRATION REPORTANCE OF TAGE (CACH DEFICIENCY MAINT BE PRECEDED BY FULL REGISTRATION REPORTANCE OF TAGE (CACH DEFICIENCY MAINT BE PRECEDED BY FULL REGISTRATION REPORTANCE OF TAGE O	DEPART	MENT OF HEALTH	AND HUMAN SERVICES	-1 .			: 06/15/20 APPROVE
NAME OF PROVIDER OR SUPPLIER 15 LAND HOME PARK HEALTH AND REHAB 16 LAND HOME PARK HEALTH AND REHAB 16 LAND HOME PARK HEALTH AND REHAB 17 LAND HOME PARK HEALTH AND REHAB 17 LAND HOME PARK HEALTH AND REHAB 18 LAND LIFE SAFETY CODE STANDARD 19 LAND LIFE SAFETY CODE STANDARD 19 LAND LIFE SAFETY CODE STANDARD 19 LAND LIFE SAFETY CODE STANDARD 10 LAND L	CENTE	RS FOR MEDICARE	& MEDICAID SERVICES C	15	7130116		
STREET ADDRESS, CITY, STATE, 2IP CODE 1758 HILLWOOD DRIVE KNOXVILLE, TN 37320	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DAT	E SURVEY
SISLAND HOME PARK HEALTH AND REHAB DOAD HOME PARK HEALTH AND REHAB SISLAND HOME PARK HEALTH AND REHAB DOAD SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MIST SE PRECEDED OF THAT REGULATORY OR LSC IDENTIFYING INFORMATION) K 018 NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Door smeeting 19.3.6.3.6 are permitted. Door frames shall be albeided and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure corridor doors were self-closing and, resist the passage of smoke and provided with a means suitable for keeping the door closed. NFPA 101, 19-3.6.3.) 33.3.3.6.4.4 (3) The findings include: 1. Observation on 6/13/2016 at 5.38 AM confirmed the dietary dishwashing room corridor doors and free from holes/pencitations. 10% of the maintenance intention of the most promption of the routine inspection schedule by the maintenance promption of the routine inspection schedule by the maintenance briection of 6/13/2016 at 5.58 AM confirmed 100 hall clean linen storage room door, so eneding replaced will be installed by 7/20/16. All corridor doors are celic-closing and resist the passage of smoke and provide an accordance of the doors. All other corridor doors that the stream of the facility is practice to ensure that corridor doors are self-closing were checked by the				B. WING _		06/12/2016	
XAU 10 SUMMANY STATEMENT OF DEFICIENCES FREE FROM STATE FREE	NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 001	10/2010
SAMMARY STATEMENT OF DEFICIENCES THE PRECEDIT OF THE APPROPHENT TAG	ISLAND	HOME PARK HEALTI	H AND REHAB				
K 018 NFPA 101 LIFE SAFETY CODE STANDARD Dors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Door shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door farmes shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3 This STANDARD is not met as evidenced by. Based on observation and interview, the facility failed to ensure corridor doors were self-closing and, resist the passage of smoke and provided with a means suitable for keeping the door closed. (NFPA 101, 19-3.6.3.) 33.3.3.6.4.4 (3) The findings include: 1. Observation on 6/13/2016 at 5.38 AM confirmed the dietary dishwashing room corridor doors are clecked by the maintenance director of/13/16 to ensure that they resist the passage of smoke and provided with a means suitable for keeping the door closed. (NFPA 101, 19-3.6.3.) 33.3.3.6.4.4 (3) The findings include: 1. Observation on 6/13/2016 at 5.38 AM confirmed 100 hall clean linen storage room door was not self-closing and was missing a middle hinge.		SUMMARY STA	ATEMENT OF DEFICIENCIES			Tron	<u> </u>
Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3 or apermitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure corridor doors were self-closing and, resist the passage of smoke and provided with a means suitable for keeping the door closed. (NFPA 101, 19-3.6.3.) 33.3.3.6.4.4 (3) The findings include: 1. Observation on 6/13/2016 at 5:38 AM confirmed the dietary dishwashing room corridor doors that are self-closing were checked by the maintenance director of 6/13/16 to ensure that they resist the passage of smoke and provided with a means suitable for keeping the door closed. (NFPA 101, 19-3.6.3.) 33.3.3.6.4.4 (3) The findings include: 1. Observation on 6/13/2016 at 5:38 AM confirmed the dietary dishwashing room corridor doors that are self-closing were checked by the maintenance director of 6/13/16 to ensure that they resist the passage of smoke and provided with a mean suitable for keeping the door closed. (NFPA 101, 19-3.6.3.) 33.3.3.6.4.4 (3) The findings include: 1. Observation on 6/13/2016 at 5:38 AM confirmed the dietary dishwashing room corridor doors that are self-closing were checked by the maintenance director of 6/13/16 on ensure that they res		(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	ULD BE	
These findings were verified by the Facilities	SS=D	Doors protecting corequired enclosure: hazardous areas slas those constructed core wood, or capa 20 minutes. Cleara and floor covering in fully sprinklered strequired to resist the no impediment to the open devices that repushed or pulled are provided with a meadoor closed. Dutch permitted. Door framade of steel or oth with 8.2.3.2.1. Rolled CMS regulations in 19.3.6.3. This STANDARD is Based on observation failed to ensure corrections and, resist the pass with a means suitable closed. (NFPA 101, 19-3.6.3) The findings included 1. Observation on 6 confirmed the dietardoor had 3 holes are 2. Observation and Maintenance Directed confirmed 100 hall cowas not self-closing hinge.	porridor openings in other than is of vertical openings, exits, or hall be substantial doors, such ad of 13/4 inch solid-bonded able of resisting fire for at least nace between bottom of door is not exceeding 1 inch. Doors smoke compartments are only the passage of smoke. There is the closing of the doors. Hold elease when the door is the permitted. Doors shall be ans suitable for keeping the doors meeting 19.3.6.3.6 are the meeting sin compliance and the materials in compliance and the materials in compliance and the meeting sin compliance and the same shall be tabeled and the materials in compliance and the same prohibited by all health care facilities. So not met as evidenced by: find and interview, the facility ridor doors were self-closing age of smoke and provided to be for keeping the door. 3.) 33.3.3.6.4.4 (3) be: So 13/2016 at 5:38 AM by dishwashing room corridor cound to knob. Interview with the for, on 6/13/2016 at 5.58 AM becan linen storage room door and was missing a middle.		Disclaimer This Plan of Correction is submitted required under State and Federal facility's submission of the Plan of does not constitute an admission of the facility that the findings cited at that the findings constitute a defice the scope and severity determinated Because the facility makes no such the statements made in the Plan of cannot be used against the facility subsequent administrative or civil taken: It is this facility's practice to ensure corridor doors are self-closing, and the passage of smoke and provide means suitable for keeping the docclosed. A bid was received to replace the edishwashing room corridor door and linen storage room door, along with hinges and hardware on 6/17/16, a doors were ordered on 6/20/16. A corridor doors that are self-closing checked by the maintenance direct 6/13/16 to ensure that they resist the passage of smoke and provide a measuitable for keeping the door closed are in proper working order and fresholes/penetrations. 100% complian noted for other doors. The doors needing replaced will be installed by 7/20/16. All corridor doors are checked more part of the routine inspection sched the maintenance director or main	Iaw. The Correction In the part of are accurate iency, or the on is correct admission Correction in any proceeding re that d resist a or dictary ad the h the ind the li other were or ine cans d and de from ince athly as ule by	of e, at et. S,
	ORATORY		ER/SUPPLIER REPRESENTATIVE'S SIGNA	ATURE	O TITLE	(2	(6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days ollowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 tays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 0U3921

Facility ID: TN4706

FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING 01 - MAIN BUILDING 01 COMPLETED 445476 B, WING 06/13/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE ISLAND HOME PARK HEALTH AND REHAB 1758 HILLWOOD DRIVE KNOXVILLE, TN 37920 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) Disclaimer K 018 | Continued From page 1 This Plan of Correction is submitted as Supervisor and acknowledged by the required under State and Federal law. The Administrator during the exit conference on facility's submission of the Plan of Correction 6/13/2016. does not constitute an admission on the part of K 038 NFPA 101 LIFE SAFETY CODE STANDARD K 038 the facility that the findings cited are accurate, SS≃D that the findings constitute a deficiency, or that Exit access is arranged so that exits are readily the scope and severity determination is correct. accessible at all times in accordance with section Because the facility makes no such admissions, 7.1. 19.2.1 the statements made in the Plan of Correction This STANDARD is not met as evidenced by: cannot be used against the facility in any Based on observation and interview, the facility subsequent administrative or civil proceeding. failed to ensure doors were operable with no taken: more than one releasing device. (NFPA 101-2000 Edition, 19.2.2.2.1 & 7.2.1.5.4) K038 It is this facility's practice to ensure that 6/16/16 doors are operable with no more than one The findings include: releasing device. Observation and interview with the Maintenance The internal bolt was removed from the Director, on 6/13/2016 at 7:47 AM confirmed the deadbolt on the electrical room door on electrical room door required 2 releasing motions 6/16/16 by the maintenance director. to exit Door knob latch and deadbolt). All other doors within the facility were This finding was verified by the Facilities checked by maintenance personnel to Supervisor and acknowledged by the ensure that there was not more than one Administrator during the exit conference on releasing device on 6/16/16. No others 6/13/2016. doors found to have more than one K 073 NFPA 101 LIFE SAFETY CODE STANDARD K 073 releasing device. SS≃E Disclaimer Combustible decorations shall be prohibited This Plan of Correction is submitted as unless they are flame-retardant or in such limited required under State and Federal law. The quantity that hazard of fire development or spread facility's submission of the Plan of Correction is not present. 18.7.5.4, 19.7.5.4 does not constitute an admission on the part of This STANDARD is not met as evidenced by: the facility that the findings cited are accurate, Based on observation and interview, the facility that the findings constitute a deficiency, or that failed to ensure combustible decorations were not the scope and severity determination is correct. highly flammable (NFPA 110, 19.7.5.4). Because the facility makes no such admissions, The findings include: the statements made in the Plan of Correction Observation, interview, and record review with the cannot be used against the facility in any Maintenance Director, on 6/13/2016 between subsequent administrative or civil proceeding.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 06/15/2016

PRINTED: 06/15/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING 01 COMPLETED 445476 06/13/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE ISLAND HOME PARK HEALTH AND REHAB 1758 HILLWOOD DRIVE KNOXVILLE, TN 37920 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION 1D PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5)PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLÉTION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) K 073 Continued From page 2 It is this facility's practice to ensure that K 073 7/1/16 all combustible decorations are not highly 5:57 AM and 7:45 AM confirmed the facility failed flammable. All door wreaths/decorations provide documentation decorations (door were treated with fire retardant material wreaths) were fire retardant or were treated with and documentation completed initially on fire retardant material. 6/15/16 maintenance director and This finding was verified by the Facilities housekeeping technician. Supervisor and acknowledged by the All items treated with the fire retardant Administrator during the exit conference on material will be tagged and logged to 6/13/2016. K 130 | NFPA 101 MISCELLANEOUS demonstrate compliance. This will be completed by 7/1/16 by maintenance SS=F director, maintenance assistant, or OTHER LSC DEFICIENCY NOT ON 2786 housekeeping technician. This STANDARD is not met as evidenced by: NFPA 80, 2010 edition states: New admissions to the facility will be informed in writing during the admissions 5.2.4.2 As a minimum, the following items shall process by the person completing be verified: (1) No open holes or breaks exist in surfaces of admissions that any door either the door or frame. decorations/wreaths will need to be given (2) Glazing, vision light frames, and glazing beads to the maintenance department for are intact and securely fastened in place, if so treatment and will be tagged and logged at that time. A letter reminding resident equipped. (3) The door, frame, hinges, hardware, and and family members that all decorations noncombustible threshold are secured, aligned, must be inspected and treated with fire and in working order with no signs of damage. retardant, and properly tagged and logged (4) No parts are missing or broken. has been drafted and will be mailed to (5) Door clearances do not exceed clearances each responsible party. listed in 4.8.4 and 6.3.1.7. Maintenance director, maintenance (6) The self-closing device is operational; that is, assistant or housekeeping technician will the active door completely closes when operated audit resident's doors for decorations to ensure that items have been treated and from the full open position. (7) If a coordinator is installed, the inactive leaf tagged five times per week for one closes before the active leaf. month, then weekly X 3 months.

frame.

(8) Latching hardware operates and secures the

(10) No field modifications to the door assembly

door when it is in the closed position.

(9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or

		AND HUMAN SERVICES			PI		: 06/15/2016 APPROVED
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			O		. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445476			(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		445476	B. WING			06/13/2016	
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 001	10/2010
ISLAND	HOME PARK HEALTH	I AND REHAR		1:	758 HILLWOOD DRIVE		
		TAND REITAD		K	NOXVILLE, TN 37920		
(X4) ID PREFIX TAG	EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
K 130	(11) Gasketing and are inspected to verintegrity. 4.8.4.1 The clearant shall be a maximum 6.3.1.7.1 The clearant vertical edges of the meeting edges of the meeting edges of dispension of the 1/8 in. ± 1/16 in. exceed 1/8 in. for with Based on observation failed to maintain fir 4.6.12.1, 8.3.3.1, Tatedition, 5.2.4.2) The findings included 1. Record review and Maintenance Director confirmed the facility door inspections. (NFPA 101 (2010 edition) (2010 e	ed that void the label. edge seals, where required, rify their presence and ce under the bottom of a door of 3/4 in. ances between the top and door and the frame, and the pors swinging in pairs, shall for steel doors and shall not good doors. on and interview, the facility e doors. (NFPA 101, 19.7.6, ble 8.3.4.2, NFPA 80 2010 etc.) d interview with the por, on 6/13/2016 at 1:55 PM of failed to conduct annual fire slition) 18/19.7.6 & 4.6.12.1; on) 5.2.1) Interview with the por, on 6/13/2016 at 6:02 AM pors by rooms 401/402 were ews.	K130		Results of these audits will be present to the Quality Assurance Performant Improvement (QAPI) committee me monthly for 3 months. The QAPI committee consists of the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursi Minimum Data Set Director, Social Services, Staff Development Coordi Activities Director, Dietary Director. Environmental Service Director. Disclaimer This Plan of Correction is submitted: required under State and Federal law facility's submission of the Plan of Codoes not constitute an admission on the facility that the findings cited are that the findings constitute a deficient the scope and severity determination. Because the facility makes no such ad the statements made in the Plan of Cocannot be used against the facility in a subsequent administrative or civil protaken: It is this facility's practice to ensure that the fire doors are maintained. Annual fire door inspection will be completed by the maintenance director 7/15/16. Annual inspections will be maintained by the maintenance director The six missing hinge screws on the fir doors by rooms 401/402 were replaced 6/21/16.	ng, nator, , and as . The rrection ie part of accurate cy, or th is correction in ceeding	of e, at et. s,

repeatedly.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 06/15/2016

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 06/15/2016 **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING 01 COMPLETED 445476 B. WING 06/13/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1758 HILLWOOD DRIVE ISLAND HOME PARK HEALTH AND REHAB KNOXVILLE, TN 37920 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) K 130 Continued From page 4 K 130 These findings were verified by the Facilities Supervisor and acknowledged by the Administrator during the exit conference on 6/13/2016.